DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND
2050 Worth Road
Fort Sam Houston, Texas 78234-6000

MEDCOM Circular
No. 40-6

25 January 2001

Expires 25 January 2003
Medical Services

LOW BACK PAIN DOCUMENTATION FORM

1. HISTORY. This issue publishes a revision of this publication. Because the publication has been extensively revised, the changed portions have not been highlighted.

2. PURPOSE.

a. This circular provides policy, forms, and implementing instructions for beta testing of a low back pain documentation form.

b. This form will facilitate, and thus improve, the documentation of practitioners in their care of patients seeking treatment for symptoms of low back pain by cueing the practitioner to document key aspects in the assessment and treatment of low back pain. These key aspects were identified by a thorough examination of the scientific evidence on low back pain by a panel of expert consultants from the Army, Navy, Air Force, and Veterans Administration (VA). The evidence on treatment of low back pain was synthesized by these experts in the Department of Defense (DOD)/VA Practice Guideline on the Treatment of Low Back Pain. These key aspects were then transformed into the low back pain documentation form.

3. APPLICABILITY. This circular applies to any practitioner using the form in the care of patients seeking treatment for low back pain in lieu of the SF 600 (Health Record--Chronological Record of Medical Care).

4. REFERENCES. AR 40-66, Medical Record Administration and Health Care Documentation, provides guidance on medical record documentation and is applicable.

5. EXPLANATION OF ABBREVIATIONS AND TERMS.

a. Abbreviations.

DOD	Department of Defense
MEDCOM	U.S. Army Medical Command
MTF	military treatment facility
OTR	outpatient treatment record
SF	standard form
VA	Veterans Administration

b. Terms. See AR 40-66.

*This circular supersedes MEDCOM Cir 40-6, 25 January 1999, including changes.

6. RESPONSIBILITIES. See AR 40-66.

7. POLICY.

a. Military treatment facilities (MTFs) may use the low back pain documentation form prescribed herein for the period of the test, through 25 January 2003, or as directed by the U.S. Army Medical Command (MEDCOM).

b. The MEDCOM test form addressed in this circular will be filed in the outpatient treatment record (OTR), with the SF 600, in chronological order.

c. The OTR form prescribed herein replaces the SF 600 only in patients being treated on an outpatient basis for treatment of low back pain.

d. All current requirements of AR 40-66, other than those addressed in this circular, remain in effect.

8. INSTRUCTIONS FOR USE OF THE LOW BACK DOCUMENTATION FORM. Note: The form authorized for local reproduction (i.e., "R" forms) is contained in appendix A of this circular.

a. Purpose. MEDCOM Form 695-R (Low Back Pain) documentation form may be used by any provider to document the treatment of patients with complaints of low back pain.

b. Preparation. This form has three sections: a vital signs section, a patient section, and a practitioner section. Section I, the vital signs section, is to be completed by ancillary staff. Section II, the patient section, is to be completed by the patient. Section III is to be completed by the provider.

c. Content. Section I, to be completed by ancillary staff, includes documentation of height, weight, vital signs, and an assessment of the duration of the low back pain. Section II, the patient section--to be completed by the patient--includes demographic, injury, symptom, work history, job characteristic, and pre-injury stress factor questions. Section III, the provider section, includes check box and free-hand areas for documentation of the patient's medical history, physical assessment, diagnosis, and treatment plan.

APPENDIX A

Appendix A contains the following "R" form (authorized for local reproduction).

MEDCOM Form 695-R (Low Back Pain)

☐ Initial visit
☐ Follow up visit

MEDICAL RECORD - LOW BACK PAIN

For use of this form see MEDCOM Cir 40-6

DATE

SECTION I - VITAL SIGNS (To be completed by Ancillary Support Staff)

Time: _____ Temp: _____ Pulse: _____ Resp: _____ BP: _____ Ht: _____ Wt: _____ Age: _____

Do you use tobacco? ☐ Yes ☐ No Want to quit? ☐ Yes ☐ No Cessation material provided? ☐ Yes ☐ No

Allergy: _____ Duration of present episode of back pain: ☐ < 6 weeks ☐ > 6 weeks

SECTION II - DEMOGRAPHICS (To be completed by Patient/Reviewed by Provider)

PART A - MEDICATIONS *(List your current medications and dose)*

PART B - INJURY / SYMPTOMS

1. Please rate the severity of your back pain during the past week by marking the pain scale below.

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain you've ever had

2. During the past week did you experience any pain, numbness or tingling in either of your legs? ☐ Yes ☐ No
3. In the past, have you experienced any of the following?

Back pain? ☐ Yes ☐ No Back surgery, or was back surgery recommended? ☐ Yes ☐ No

Back rehabilitation? ☐ Yes ☐ No Pain, numbness or tingling in either of your legs? ☐ Yes ☐ No

4. Please rate your current stress level by marking the stress scale below.

No stress 0 1 2 3 4 5 6 7 8 9 10 High Stress

PART C - WORK HISTORY / JOB CHARACTERISTICS

1. What is your current job title (civilian) or MOS (military) and work site: _____
2. Does your job require (check all that apply):

☐ Lifting? How often? _____ /hour ☐ Twisting your back while lifting or lowering?

☐ Lifting objects overhead? How often? _____ /hour ☐ Use of vibrating equipment or tools?

☐ Pushing/Pulling? How often? _____ /hour ☐ Sitting for long periods without getting up?

SECTION III - MEDICAL HISTORY, ASSESSMENT, DIAGNOSIS, AND TREATMENT *(To be completed by Provider)*

Patient's chief complaint:

PART A - HISTORY OF PRESENT ILLNESS

1. Cause of back pain: ☐ Non-Traumatic ☐ Traumatic *(Describe below)*:

2. If non-traumatic, does the patient have any of the following red flag risk factors?

Age > 50	☐ Yes	☐ No	History of cancer	☐ Yes	☐ No
Fevers	☐ Yes	☐ No	Metabolic disorder	☐ Yes	☐ No
Night pain	☐ Yes	☐ No	Bowel or bladder symptoms	☐ Yes	☐ No
Unexplained weight loss	☐ Yes	☐ No	Saddle anesthesia	☐ Yes	☐ No

Comments:

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

_____
(Patient's Signature)

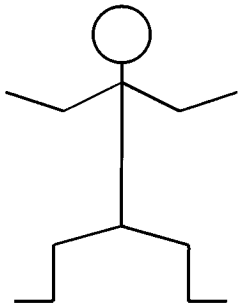
PART B - PAST MEDICAL HISTORY

- ☐ Duodenal ulcer
- ☐ Pancreatitis
- ☐ Irritable bowel syndrome
- ☐ Diverticulitis
- ☐ Abdominal aortic aneurysm
- ☐ Pyelonephritis
- ☐ Prostatism
- ☐ Ovarian disease
- ☐ PID
- ☐ Vascular claudication

Comments: _____

PART C - PHYSICAL ASSESSMENT

Posture	☐ Normal	☐ Abnormal
Gait	☐ Normal	☐ Abnormal
Straight leg raise	☐ Normal	☐ Abnormal
Reflexes (knee, ankle, babinski)	☐ Normal	☐ Abnormal
Sensation (L4-5 / S1)	☐ Normal	☐ Abnormal
Strength (L4-5 / S1)	☐ Normal	☐ Abnormal
ROM (flex/ext/RSB/LSB/ro)	☐ Normal	☐ Abnormal
Wadells sign	☐ Normal	☐ Abnormal
Tender to palpation:	☐ No	☐ Yes



Comments or description of abnormalities: _____

PART D - DIAGNOSIS

☐ Acute low back pain ☐ Chronic low back pain ☐ Acute sciatica ☐ Chronic sciatica / limb pain

☐ Other *(Specify)*: _____

PART E - TREATMENT PLAN

1. **MEDICATION:** ☐ Acetominophen 500 mg 1-2 po every 4 hr ☐ ASA 325 mg 1-2 po every 4 hr
   ☐ Ibuprofen 600/800 mg po every 8 hr ☐ Other *(Specify)*: _____
2. **IMAGING** *(Indicate type and reason)*: ☐ X-ray ☐ MRI or ☐ CT Myelogram ☐ Other: _____
   - ☐ > 50 or < 18 years of age
   - ☐ Pain at rest or night pain
   - ☐ No history of CA
   - ☐ Fever > 38C or 100.4F > 48 hours
   - ☐ Neuromotor deficit
   - ☐ No improvement in 4-6 weeks
   - ☐ R/O ankylosing spondylitis/spondylo-arthropathy
   - ☐ Low energy trauma in high risk patient (osteoporosis)
   - ☐ High energy trauma (fall from height, MVA)
   - ☐ History of drug/alcohol abuse
   - ☐ Other *(Specify)*: _____
3. **LAB:** _____
4. **REFERRAL:**
   - ☐ Self-care
   - ☐ Self-care patient materials provided
   - ☐ Advised to reduce weight
   - ☐ Referral to dietician for weight reduction
   - ☐ Advised about stress management
   - ☐ Referral to stress management
   - ☐ Advised to stop using tobacco
   - ☐ Referral to tobacco cessation program
   - ☐ Referral to back class/school
   - ☐ Referral to physical therapy
   - ☐ Referral to neuro surgeon
   - ☐ Referral to orthopedic surgeon
   - ☐ Other *(Specify)*: _____
5. **DUTY STATUS:** ☐ Full activity ☐ Modified duty ☐ Quarters _____ ☐ Comment: _____
   ☐ Profile _____
6. **FOLLOW-UP:** ☐ None ☐ 48 hours ☐ 1-3 weeks ☐ 6 weeks
   ☐ Patient instructed to contact clinic ASAP if symptoms worsen.

_____ _____

(Provider's Name) *(Provider's Signature)*

(MCHO-Q)

FOR THE COMMANDER:

PATRICK D. SCULLEY
Major General
Chief of Staff

THOMAS J. SEMARGE
Colonel, MS
Assistant Chief of Staff for
Information Management

DISTRIBUTION:
Ca; Da

SPECIAL DISTRIBUTION:
MCHC (Stockroom) (10 cy)
MCHC (Library) (1 cy)
MCHS-AS (Forms Mgr) (1 cy)
MCHS-AS (Editor) (2 cy)